Sensation on the left side of the face is practically normal. The atrophy of the left temporal and masseter muscles is much less marked, and the patient can bite well with the left side of the jaw. The ocular movements are perfect; no reduction of the visual field; left pupil is slightly larger than the right; both pupils react to light and accommodation, but still sluggishly; no mystagmus. Tongue is protruded straight, and there is no atrophy of its muscles. Shooting pains are much less marked in the lower extremities. Numbness of feet continues, though inordination of the lower extremities is much less marked. Patient still sways considerably on standing with the eyes closed, but less than when last examined; knee jerks still completely absent; no muscular atrophy. The incontinence of urine continues, though the patient says he can now feel the urine passing through the urethra. Bowels are normal. Weight 176 pounds.

At the end of last week I was fortunate enough to be able to make another examination of the larynx of my patient. Speech was as clear, if not clearer than before, although he fancied that at times his voice was somewhat thicker, and enunciation not so clear. The vocal cords are not lying in apposition, but are separated about one-eighth of an inch throughout their entire length, coming together in phonation. In inspiration there is a distinct lagging of the cords towards each other, and no perceptible movement of abduction could be made out. The position of the cords is not cadaveric but perhaps points to a weakening of the power of abduction. When the finger was placed over the mouth of the tracheotomy tube patient stated that he breathed with more ease than formerly.

Diagnosis: Tabes dorsalis with bilateral involvement of the bulbar, neuclei of the spinal accessory and urilateral involvement of the facial, trigeminal, and slightly of the oculo-motor nerves.

While some of the classical symptoms of locomotor ataxia, as the Argyle-Robertson pupil, are absent, and while the improvement in the patient's condition to so considerable an extent is unusual, still the absent knee jerks, Romberg's sign, the lightening pains, the altered sensations in the feet, slight inco-ordination and the bladder symptoms, occurring in a patient with a previous of history of syphilis, are sufficient to justify this opinion.

In his last edition McBride (2), after re-stating Semon's well-known law, "that paresis confined to the abductors is commonly, if not always due to organic changes in the pneumogastric or recurrent trunk, or in the medulla," goes on to say that having had access to the manuscript of a work now in